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2015 JUN -2 PM 5:11

June 3, 2015

City and County of Honolulu
Budget Hearing

Bill: 13

Relating to the Executive Capital Budget and Program
July 1, 2015 – June 30, 2016

Good morning Chair Martin, Vice-Chair Anderson, Councilmembers Pine, Ozawa, Kobayashi, Manahan, Fukunaga, Menor and Elefante! Thank you for the opportunity to submit written testimony before you today.

I am Victoria Page, Executive Vice-President of Health Innovations for the National Kidney Foundation of Hawaii.

Chronic kidney disease (CKD) is a public health problem beset by inequities across age, gender, race/ethnicity, and socioeconomic status. Over 26 million American adults have chronic kidney disease (CKD) and 73 million are at-risk. Kidney disease is the 9th leading cause of death. 24% of Medicare costs are related to this chronic illness. Almost 600,000 people are at end-stage and cannot recover. Many die, some are saved by dialysis (415,000) and others by transplant (179,000). Sadly, an average of 13 people died each day while waiting for a kidney transplant. Individuals with CKD are far more likely to die from cardiovascular complications than to even reach kidney failure.

It is important to understand that kidney disease is a unique condition as it carries a multiplier effect where the negative impact of co-morbidities is greater than the sum of the effects of a single disease. For example, the main causes of CKD are diabetes and cardiovascular disease and a recent study showed that persons with heart disease and kidney disease were 35% more likely to have recurrent cardiovascular events or die than persons with cardiovascular disease alone.

In Hawaii, it is estimated that 165,000 individuals are affected and even more are at-risk, but many have no idea. Kidney failure is 30% higher in Hawaii, with almost 3,000 people surviving with dialysis and close to 400 are awaiting a life-saving organ transplant. Unfortunately, CKD disproportionately affects the Native Hawaiian/Pacific Islander and other disparate minority communities in our State.

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To make matters worse, there is severe shortage of medical providers and healthcare resources available to address this growing epidemic. Hawaii is one of the hardest hit by this reality as we currently only have less than 30 practicing nephrologists to manage 3,000 dialysis patients. Declining community health, escalating costs, and compromised quality of care is driving the National Kidney Foundation of Hawaii (NKFH) to respond with innovative strategies, prevention activities, public education, and patient and family services.

With the growing population of baby-boomers, our current health care and social security systems are seeing more and more people living with chronic diseases and the host of health complications that come with these diseases. Careful monitoring of an individual's health care regimens, more specifically self-management, is quickly gaining popularity as one of the most effective ways to manage one's health and reduce health complications, excessive and unnecessary costs to the individuals.

Many of the individuals suffering from kidney disease are elderly, disabled, socioeconomically disadvantaged. As of 2013, about 3139 Hawaiian residents are relying on dialysis treatments in order to stay alive. Of the 3139 dialysis patients, 1806 are people over the age of 60. Many of these patients currently live with more than one chronic conditions and a host of secondary symptoms that render many of them helpless and unable to even keep up with their basic self-care. This creates an additional challenge for these patients to adhere to treatment plans. Due to low health literacy and their circumstances, these patients have missed treatment sessions, forgotten to take medications, and been unable to follow strict dietary and activity recommendations. As a result, these individuals find themselves needing additional costly medical services and worsening in health & quality of life.

Therefore, the National Kidney Foundation of Hawaii (NKFH) would like to create a Community Health Navigator (CHN) program which cultivates and empowers community members with skills to provide individualized support to chronic disease patients facing barriers to proper care. Not only will the CHN help increase patient access to medical services and patient assistant programs, they will be uniquely positioned to provide culturally-sensitive guidance for patient self-management and adherence to care plans.

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The target population for this program includes those with kidney disease and other related chronic illnesses that are challenged by advanced age, physical disabilities, and socioeconomic limitations. Community Health Navigators will be comprised of community members that will receive basic health and peer support training. Many of the CHNs will be facing the same disadvantages and chronic conditions as the patients they serve as which will enhance their ability help others and facilitate program success.

Many seniors and disabled individuals struggle with the concept of self-management due to low health literacy level and the physical limitations that prevents them from adhering to the concept of Chronic Disease Self-Management. The Community Health Navigator (CHN) Program aims to increase health literacy level among this patient population and to provide them the necessary support network that is crucial to being successful at self-management care. The ultimate goal for this program is to create an informed, abled and well-supported patient population. As patients become more aware of their health and how to effectively manage their care, to reduce unnecessary complications and hospitalization, they will be able to remain more independent, more active and empowered in their own health decisions and have an improved quality of life.

The Community Health Navigators will receive extensive training on the causes and effects of CKD and related conditions as well as training in the following aspects of care:

- **Comprehensive Care Management:** understand the working system of a multi-disciplined health care team and possess the ability to assist patients in navigating this complex model of care.
- **Care Coordination and Health Promotion:** link/refer patients to needed services (patient education, fitness groups, etc.) to support care plan and treatment goals. Training will also be provided on how to recognize early symptoms of complications and how to properly handle such incidences.
- **Patient & Family Support:** Facilitate any needed interpretation services between patients/caregivers and providers.
- **Referral to Community & Social Support Service:** Refer patients and their families to peer supports, support groups, social services and entitlement programs as needed. Services to be provided to patients by Community Health Navigators will include careful explanation and interpretation (if needed) of one's health condition, treatment options and the necessary medical instructions to maintain one's health. CHNs will also conduct

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frequent follow up contacts to ensure that patients are following their self-management regiment as well as answering any questions and/or connecting patients to appropriate additional supportive resources such as financial assistance sources, transplant center, additional educational materials, etc. Community partners like healthcare providers (physicians, clinics, community health centers, etc.) will also be encouraged to refer participants into the program.

Thank you for your support and the opportunity to submit testimony before you today.

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